King County Accountable Community of Health
Interim Leadership Council Meeting
June 6, 2016, 1:00 pm – 4:00 pm
NEW LOCATION *Seola Gardens Com Room, 11215-5th Ave SW, Seattle , WA 98146*

MEETING GOALS
The primary objectives of today's meeting are to (1) review SIM projects under consideration against State and ILC criteria and make a project selection decision, (2) learn about King County's progress towards full physical-behavior health integration, and (3) gain greater insight into the data and performance measurement landscape affecting ACHs.

AGENDA

1:00 p.m.	**1. Welcome and Introductions**	Gena Morgan; All
1:10 p.m.	**2. Meeting Goals & Agenda Review**	Gena Morgan
1:15 p.m.	**3. SIM Projects** ▪ Review of State Expectations ▪ Analysis of Projects Under Consideration ▪ **Action Item:** ILC Project Selection	Christina Hulet; All
2:15 p.m.	**BREAK**	
2:30 p.m.	**4. Interested Parties Comment Period**	
2:40 p.m.	**5. Physical & Behavioral Health Integration Developments** ▪ Update: The Pathway to Full Integration	Susan McLaughlin, "Kitchen Cabinet" members; All
3:10 p.m.	**6. Performance Measurement Workgroup** ▪ CORE Dashboard ▪ DASH Grant Update	Marguerite Ro & others
3:35 p.m.	**7. ACH Developments** ▪ Sharing of ACH Activities from Around the State ▪ Plan for Improving Population Health ▪ Governance Subcommittee ▪ Staff Report	Gena Morgan; Christina Hulet; All
3:55 p.m.	**Next Steps**	
4:00 p.m.	**Meeting Adjourn**	

Next Meeting: Monday, July 18, 2016, 1:00 – 4:00 pm (location TBD). Refreshments and networking at 12:30 p.m.

King County Accountable Community of Health
May 2016 Staff Report

Date: May 26, 2016

To: Members of the King County ACH Interim Leadership Council (ILC)

From: Gena Morgan, Public Health-Seattle & King County

Please review the following and come prepared with your questions to the June 6 meeting. Also, we welcome your feedback on this report, including how to make it most useful to you.

1. Medicaid Waiver Update

The Health Care Authority (HCA) hosted a webinar on April 26 to provide updates on negotiations with the Centers for Medicare and Medicaid Services and the work in progress on the 3 Initiatives. They also released the Framework for the Medicaid Transformation Waiver [Project Toolkit](#) from which the final toolkit will be built. You may want to view the [webinar video](#) or review the [slide deck](#). A [Frequently Asked Questions](#) document was also recently updated.

An ACH Waiver Workgroup, including participants from 4 ACHs, managed care plans, community organizations and State partners, have been meeting to work through issues related to the implementation of the Medicaid Waiver. King County staff have been invited to the meeting that will take place on May 26 and will bring any updates to the ILC at the June 6 meeting.

2. Tribal Consultation on Accountable Communities of Health

The American Indian Health Commission (AIHC) for Washington State, on behalf of the 29 tribes and 2 urban Indian health organizations (UIHO), convened a consultation between tribes and the Health Care Authority on May 11. Representatives from each ACH were asked to attend as well. The purpose of the meeting was to review and discuss a tribal consultation policy put forward by the tribes and UIHOs on how they would like ACHs to engage with them. Steering Committee member Laurel Lee attended the May 11 consultation, representing the King County ACH. Staff will be working with Laurel Lee and Aren Sparck to provide comments back to the Health Care Authority on the tribal consultation policy.

3. ACH Quarterly Convening

The Health Care Authority convenes ACHs from across Washington State for quarterly meetings. The next quarterly convening will be June 29-July 1 in Chelan, Washington. The agenda is currently under

development, but will include a segment on ACH sustainability. The Health Care Authority has invited 2 staff and 2 ILC members to attend. Marguerite Ro, Gena Morgan, and Amina Suchoski will be attending on behalf of the King County ACH. There is one remaining seat available to an ILC member. Please let Gena know if you would like to attend.

4. RFP for King County ACH Governance Consulting

Between mid-April and mid-May, an RFP was run through King County Procurement for an ACH Governance Consultant. The purpose of the RFP is to provide strategic guidance, analyses, recommendations and facilitation for the development of the governance and administrative structure for the next phase of the King County region ACH. This RFP continues the governance work initiated earlier this year and will provide the ACH ILC with support post-Medicaid Waiver. Three proposals were received and are currently under review. Steering Committee members and staff will be making a decision shortly on ACH governance for the next phase of work.

5. Staff Hiring

As you know, Seattle-King County Public Health (SKCPH) upgraded the Administrative Specialist position to a Program/Project Manager I (PPMI) position with the departure of our administrative support person. After a series of interviews with multiple candidates in April, Candace Jackson, with the Preparedness section of SKCPH, was offered and has accepted this position. We look forward to introducing you to her at the June 6 meeting.

6. Subcommittees, Workgroups and Initiatives

Governance Subcommittee

The Governance Subcommittee had its first meeting on May 17 and will have its next meeting on May 31. The group discussed its goal of developing recommendations for the ILC on the ACH's governance process and organizational structure, and options for how the ACH might organize its core work. Consultant Christina Hulet is facilitating these meetings. The subcommittee will provide further updates at the June 6 ILC meeting.

Performance Measurement Workgroup (PMW)

The Performance Measurement Workgroup met on May 18. The primary agenda items were to provide PMW members an overview of the ILC project selection criteria under the State Innovation Model (SIM) grant and discuss State plans to help meet ACH data needs through the ACH dashboards. The PMW's next meeting is on June 15. Members will complete and present their privacy and legal resource slide deck.

Communities of Opportunity Initiative

The 16 members of the Communities of Opportunity Interim Governance Group spent two days at a retreat in SeaTac May 12-13, designing how the work of COO will expand and shift over the next five years with Best Starts for Kids resources.

After two intensive days of work (and fun), the Interim Governance Group completed a design lab on initial plans for a COO Learning Community or "Catalyzing Community Change Network" and laid out a five-year work plan for what it will take to "turn the red part of the map to blue." Change at this scale will involve collective action on many public and private sector fronts and won't happen overnight. Map images and more information are at: www.kingcounty.gov/coo

Physical – Behavioral Health Integration (PBHI)

The Physical and Behavioral Health Integration Design Committee (IDC) has been meeting since November 2015 to develop a recommended model of integrated care for the King County region. The IDC has recently formed workgroups to delve further into clinical design for three sub-populations including children and families, adults and elderly, and hard to reach populations (such as homeless and immigrants). Another workgroup will be focused on infrastructure and financing. The IDC will bring initial recommendations on clinical design, infrastructure and financing and timing to the ACH ILC in September 2016. We will hear an update on PBHI at the June 6 ILC meeting.

7. King County ACH Steering Committee

The King County ACH Steering Committee met on May 16 to debrief the May 9 ILC meeting. They discussed the Tribal Consultation on May 11, the ACH financial management function under a Medicaid Waiver, consulting contracts and the governance consultant RFP, and next steps for SIM project selection.

8. Contract and Budget Updates

As of May 17, 2016, Public Health had expended 86% of the $150,000 ACH phase 1 grant from the Health Care Authority. Expenses to date include $48,000 in salary costs (Morgan, McVay and Bogan), $47,000 in consulting charges (Cedar River Group, Hulet and Watanabe Consulting), and $1,000 in equity network member stipends (Center for MultiCultural Health). When the phase 1 grant is expended, spending will begin on the $330,000 phase 2 grant amendment.

SIM Project Selection
Decision Making Guide – June 6, 2016 ILC Meeting

At its upcoming meeting in June, the ILC will select a project for the Health Care Authority's SIM grant. Below is a decision making guide to facilitate the process, which includes both state requirements and criteria developed by the ILC.

State Requirements	Housing/Health	Familiar Faces
1. Measurable progress in timeframe (2018) • Potential impact on individuals, not just capacity building • If targeting Medicaid population, ACH activities extend beyond • Activities and measures clearly defined	• Expect measurable progress by 2018. • Population served is high % Medicaid, but extends beyond. • Activities underway are seeking ACH guidance on areas with priority impact and creation of metrics to track progress.	• *Potential for impact on individuals by 2018?* • Does extend beyond Medicaid • Activities and measures defined
2. Value-add of ACH • Linking projects targeting the same health area to promote learning and reduce duplication • Connecting to new sources of funding to increase impact/spread • Leveraging Healthier WA initiatives, if appropriate (e.g., practice transformation hub) • Removing barriers	• Provide guidance on interventions and on metrics for evaluating housing-based health interventions • Advocacy for increasing affordable housing resources • Support for housing-health data integration. • Better understand the full picture/systems view (e.g., health profile of public and affordable housing residents, and opportunities to scale up institutional collaboration between housing and health delivery)	• Consolidate and coordinate data • Understand "full picture" of services across systems
3. Alignment with state's Core Measure Set • "At least one" • See attached list	• Influenza immunizations • Access to preventative services • BMI assessments • Breast cancer screening • Diabetes testing/mgmt • Blood pressure control • Possible: child wellness and prevention measures • Possible: depression	• Substance abuse • Avoidable ED visits
4. Multi-sector work • Various sectors involved in the project planning/execution	• Mercy Housing NW, King County's Public Health and Department of Community and Human Services, housing authorities of Seattle + King County, Boeing, Gates Foundation, Neighborcare, Global to Local, HealthPoint, WLIHA, Housing Development Consortium, Healthy Generations, MCOs, Building Changes, PHPDA, Enterprise	• Housing providers, substance use disorder providers, mental health providers, community health centers, MCOs, King County's Public Health and Department of Community and Human Services, the City of Seattle, criminal justice organizations including courts, police, and the King County Department of Adult and Juvenile Detention
5. Health equity • Strongly encouraged, not required	• Yes • Target population: very low-income families with kids and seniors. Large % immigrant and/or people of color.	• Yes • Target population: people with high jail use (4 or more times per year) with behavioral health conditions, 18 & older

ILC Criteria / Items to Consider	Housing/Health	Familiar Faces
6. **SIM/waiver alignment**	• Not a strong waiver project—one goal of being RHIP is gathering more documentation of cost savings.	• Familiar Faces could be waiver project
7. **Funding required** • Note: state has made a request to CMS for $50k per SIM project	• $250,000 - $300,000 required • Communities of Opportunity has committed $50K.	• *To discuss at ILC*
8. **Data collection/coordination** • Can the ACH raise the visibility of data collection and coordination to leverage/scale a project to a greater extent?	• RWJ DASH grant scope for PHSKC includes integration of public housing with Medicaid claims data. Can potentially build on that with MCO data analysis of targeted affordable housing sites. • Also working to combine PHA data and possible WBARs with state HCA interactive database that CORE is doing for ACH's	• *To discuss at ILC*
9. **Potential for system change** • What kind of systems change would the ACH help drive?	• Use of affordable and public housing as a platform to prevent and manage chronic disease among low-income, vulnerable residents.	• *To discuss at ILC*
10. **Population size/context**	• Approximately 8,000 residents in affordable and public housing developments with community health workers and other housing-based interventions.	• Approximately 1200-1300 individuals booked 4+ times/year • Of these, an estimated 94% have behavioral health condition, 93% have at least one acute medical condition, 51% have at least one chronic condition, and more than 50% are homeless.

Washington State Common Measure Set on Health Care Quality and Cost – 2016 (Approved January 2016)

MEASURE	MEASURE STEWARD	DATA SOURCE	PUBLIC REPORTING – RESULTS AVAILABLE BY:				
			State	County/ ACH	Health Plan	Medical Group	Hospital
Access to Primary Care and Prevention – Children/Adolescents							
Child and Adolescent Access to Primary Care Providers	NCQA	WHA*	✓	✓	✓		
Well-Child Visits - Ages 3–6 years	NCQA	WHA*	✓	✓	✓	✓	
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	NCQA	Health Plans via NCQA	✓		✓		
Oral Health: Primary Caries Prevention Offered by Primary Care (Medicaid population only)	HCA	HCA	✓	✓			
Immunizations: Childhood Status	NCQA	DOH – WA/IIS	✓	✓			
Immunizations: Adolescent Status	NCQA	DOH – WA/IIS	✓	✓			
Immunizations: HPV Vaccine for Adolescents (Male and Female)	NCQA	DOH – WA/IIS	✓	✓			
Access to Primary Care and Prevention – Adults							
Adult Access to Primary Care Providers	NCQA	WHA*	✓	✓	✓		
Weight Assessment (BMI) for Adults	NCQA	Health Plans via NCQA	✓		✓		
Adult Tobacco Use	CDC	DOH - BRFSS	✓	✓			
Medical Assistance with Smoking and Tobacco Use Cessation	NCQA	Health Plans via NCQA	✓		✓		
Unintended Pregnancies	CDC	DOH - PRAMS	✓				
Immunizations: Influenza	AMA-PCPI	DOH – WA/IIS	✓	✓			
Immunization: Pneumonia Vaccination - Ages 65+	CDC	DOH - BRFSS	✓	✓			
Health Screening: Colorectal Cancer *(Commercially Insured Population Only)*	NCQA	WHA*	✓	✓	✓	✓	
Health Screening: Breast Cancer	NCQA	WHA*	✓	✓	✓	✓	
Health Screening: Cervical Cancer	NCQA	WHA*	✓	✓	✓	✓	
Health Screening: Chlamydia	NCQA	WHA*	✓	✓	✓	✓	

WHA* = The Washington Health Alliance produces results for the state, counties, ACHS, and medical groups. Health Plan results are drawn from NCQA Quality Compass.

Health Plans* = Results are generated directly by the health plans and submitted to the Washington Health Alliance for reporting (not available via NCQA Quality Compass).

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MEASURE	MEASURE STEWARD	DATA SOURCE	PUBLIC REPORTING – RESULTS AVAILABLE BY:				
			State	County/ ACH	Health Plan	Medical Group	Hospital
Behavioral Health							
Adult Mental Health Status	CDC	DOH - BRFSS	✓	✓			
Follow-up After Hospitalization for Mental Illness @ 7 days and 30 days	NCQA	Health Plans via NCQA	✓		✓		
Follow-up After Discharge from ER for Mental Health, Alcohol or Other Drug Dependence @ 30 days ⭐	NCQA	Health Plans*			✓		
Mental Health Service Penetration (Broad Version) ⭐	DSHS	Health Plans*/DSHS			✓		
Substance Use Disorder Treatment Penetration *(Medicaid Insured Population Only)* ⭐	DSHS	DSHS			✓		
30-day Psychiatric Inpatient Readmissions *(Medicaid population only)*	DSHS	DSHS	✓				
Depression: Medication Management @ 12 weeks (Acute Phase) and 6 months (Continuation Phase)	NCQA	WHA*	✓	✓	✓	✓	
Effective Management of Chronic Illness in the Outpatient Setting							
Medication Management for People with Asthma ⭐	NCQA	WHA*	✓	✓	✓	✓	
COPD: Use of Spirometry Testing in Diagnosis	NCQA	WHA*	✓	✓	✓		
Hospitalization for Chronic Obstructive Pulmonary Disorder (COPD) or Asthma	AHRQ	WHA*	✓	✓			
Diabetes: Blood Sugar (HbA1c) Testing	NCQA	WHA*	✓	✓	✓	✓	
Diabetes: Blood Sugar (HbA1c) Poor Control (>9.0%)	NCQA	Health Plans via NCQA	✓		✓		
Diabetes: Eye Exam	NCQA	WHA*	✓	✓	✓	✓	
Diabetes: Kidney Disease Screening	NCQA	WHA*	✓	✓	✓	✓	
Diabetes: Blood Pressure Control (<140/90 mm Hg)	NCQA	Health Plans via NCQA	✓		✓		
Cardiovascular Disease: Blood Pressure Control	NCQA	Health Plans via NCQA	✓		✓		

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⭐ = New measure in 2016.   ⭐ = New/Replacement – new measure replaces 2015 measure that is no longer supported by measure steward.

Washington State Common Measure Set on Health Care Quality and Cost – 2016 (Approved January 2016)

MEASURE	MEASURE STEWARD	DATA SOURCE	PUBLIC REPORTING – RESULTS AVAILABLE BY:				
			State	County/ ACH	Health Plan	Medical Group	Hospital
Statin Therapy for Patients with Cardiovascular Disease ⭐	NCQA	WHA*	✓	✓	✓	✓	
Medication Safety: Adherence to Prescribed Medications (3 types)	PQA	WHA	✓	✓		✓	
Medication Safety: Monitoring Patients on Hypertension Medications	NCQA	WHA*	✓	✓	✓	✓	
Generic Medication Prescribing (5 types)	Alliance	WHA	✓	✓		✓	
Patient Experience with Primary Care (Provider Communication)	AHRQ	WHA	✓			✓	
Ensuring Appropriate Care: Avoiding Overuse							
Appropriate Testing for Children with Pharyngitis (before use of antibiotics)	NCQA	WHA*	✓	✓	✓	✓	
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	NCQA	WHA*	✓	✓	✓	✓	
Avoidance of X-ray, MRI and CT Scan for Low Back Pain	NCQA	WHA*	✓	✓	✓	✓	
Potentially Avoidable ER Use	GHC	WHA	✓	✓		✓	✓
Emergency Department Visits per 1,000 ⭐	NCQA	Health Plans via NCQA			✓		
Effective Hospital-Based Care							
30-day All-Cause Hospital Readmissions *(Commercially-insured Population Only)*	NCQA	WHA*	✓	✓	✓	✓	✓
Cesarean Deliveries	TJC	WSHA	✓				✓
Hospital 30-Day Death (Mortality) Rates for Heart Attack	CMS	WSHA/CMS					✓
Catheter-associated Urinary Tract Infections	CDC	WSHA	✓				✓
Stroke Care: Timely Thrombolytic Therapy	TJC	WSHA	✓				✓
Patient Falls with Injury	DOH/ANA	WSHA	✓				✓
Patient Safety for 11 Indicators (Composite)	AHRQ	WSHA/CMS					✓
Patient Experience (Discharge Information, Medicines Explained)	CMS	WSHA/CMS					✓

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⭐ (green) *= New measure in 2016.*   ⭐ (yellow) *= New/Replacement – new measure replaces 2015 measure that is no longer supported by measure steward.*

Washington State Common Measure Set on Health Care Quality and Cost – 2016 (Approved January 2016)

MEASURE	MEASURE STEWARD	DATA SOURCE	PUBLIC REPORTING – RESULTS AVAILABLE BY:				
			State	County/ ACH	Health Plan	Medical Group	Hospital
Cost of Care							
Annual Per-Capita State-purchased Health Care Spending Growth Relative to State GDP	HCA	HCA	✓				
Medicaid per Enrollee Spending	HCA	HCA	✓				
Public Employee per Enrollee Spending	HCA	HCA	✓				

ACH SIM Project Selection Framework

From Pages 10-12 from the ACH Guidelines Document

2.4.2   Project Selection and Implementation

As part of their scope of work ACHs are required to develop and implement effective, collaborative regional health improvement plans (RHIPs) and at least one regional health improvement project, with clearly defined and agreed upon measures of progress and outcomes.

Below is guidance regarding what constitutes a regional health improvement project..

Health Improvement Project Requirements and Definitions

An ACH regional health improvement project is a set of coordinated activities focused on one or more health priority areas designed to create measurable progress toward a regional health improvement plan goal. HCA strongly encourages ACHs to consider health equity within the context of project selection and implementation. Defining some terms:

- Coordinated means multi-sector ACH participants are involved in project planning or execution.
- Health priority areas can be condition-specific (e.g., diabetes, hypertension, obesity) or related to a specific approach (e.g., behavioral health integration, care management, community health workers).
- Related to a regional health improvement plan goal means that the project will help advance one or more goals specified in the ACH's Regional Health Improvement Plan that link to the Triple Aim.

Activities and *measureable progress* need to be defined concretely. Regarding activities, a key question for a project is whether it must start from scratch or build on things that already exist. Both approaches are allowed and activities may involve:

- Starting a new project – a new program or intervention that does not directly build on one that currently exists; or
- Enhancing an existing project or set of projects, through distinct value-added ACH activities, including but not limited to:

  o Linking existing projects targeting the same health area to promote cross-project learning and avoid duplication of effort

  o Connecting existing projects to new sources of funding to increase their spread/impact

  o Leveraging Healthier WA initiatives if appropriate – e.g. the practice transformation hub

  o Working to remove barriers to the spread and functioning of existing projects

Measureable progress toward a health improvement plan goal means that the project improves the health/well-being of a population within the region in a way that can be measured. The following are notes to help clarify requirements around both "measurability" and "impact:"

- The project must have the potential to impact individuals within the time frame of the SIM grant. For example, it cannot be solely focused on building capacity among or within organizations to do a project in the future;
- The target population can be a smaller subset of the regional population. If the target population is Medicaid beneficiaries specifically, the ACH must include activities that extend beyond the Medicaid

3.7.16

ACH SIM Project Selection Framework

From Pages 10-12 from the ACH Guidelines Document

population (i.e., planning or implementation could include mechanisms for shared learning and spread, or reinforcing activities from ACH partners that extend beyond the target population);~~;~~

- Project impact may include process measures. For example, enrolling people in health insurance, improving screening rates – but those must be at the individual rather than project level;
- For projects that are enhancing existing efforts, the "impact" is the value added by the ACH to the outcomes currently being produced (i.e. clearly measuring what occurred because of ACH involvement that would not have occurred without the ACH's contribution);
- Efforts must be made to measure the impact of the health improvement project within the timeframe of the initiative, although it may not be possible to do so given resource constraints or data availability; and
- Project outcomes must be in alignment with at least one of the 52 Core Measure Set variables.

Deliverables and Timeline

Deliverables will include an action plan that describes the project activities, objectives, and outcomes, along with regular reports on progress. The action plan will include:

- Objectives, with concrete, measureable outcomes
- Activities – narrative description of what will be done as part of the evidence-based project
- Workplan – document with a high-level timeline of specific activities and roles and responsibilities for those activities
- Evaluation approach – description of how outcomes will be measured

The progress reports will include:

- Description of current status tied to the workplan elements
- Barriers, challenges that have impacted progress and how addressed

Timeline:

- Target project selection is Q1-Q2 of 2016.
- Target project implementation, as outlined in an action plan, is Q3 of 2016.

Support

Guidance and support from the HCA ACH team and/or CCHE will be provided for all phases of the project:

- Project planning – working with ACHs to identify and develop project plans that will satisfy the deliverable requirements and be feasible to execute
- Implementation – assisting with creating realistic workplans and overcoming barriers to implementation
- Evaluation – defining measures, identifying potential data sources, and helping to conduct analyses

King County ACH Potential Regional Health Improvement Project (RHIP)—Housing & Health Partnership

Prevention and Management of Chronic Disease in Low-Income and Immigrant Populations through Housing-based and Community Health Worker Interventions in King County

Summary: Project goal is to demonstrate and measure a "proof of concept" for health and wellness interventions in affordable and public housing and in communities with very low-incomes and many immigrant residents.

Housing-Health Partnership: The Washington Housing-Health Partnership has met for the past 18 months. Convened by Mercy Housing Northwest, participants include Public Health Seattle & King County, WA Health Care Authority and Department of Health, the housing authorities of Seattle, King County, Tacoma and Spokane, Boeing, Bill & Melinda Gates Foundation, Neighborcare, Global to Local, Cedar River Group, Seattle College, King County Department of Community and Human Services (DCHS), Foundation for Healthy Generations, several MCO's, Building Changes, PHPDA, Enterprise and other entities who have embraced the common goal of developing a sustainable and scalable business model for affordable housing-based and community based interventions to promote health.

The recent report from Enterprise Community Partners, done by the Center for Outcomes Research and Education (CORE) titled "Health in Housing: Exploring the Intersections between Housing and Health Care," showed compelling results in a Portland, Oregon. Looking at 148 housing projects that are home to 10,000 residents, the study found a 12% average reduction in Medicaid expenditures after residents moved into affordable housing. Our goal is to carry this research further by refining and measuring the impact of integrated health and prevention services in affordable housing and in low-income communities that have disproportionately poor health outcomes.

Affordable Housing Leads to Better Health

Primary Care Visits +20%

Emergency Visits -18%

Medicaid Costs -12%

Access and Quality +40%

Integrated Services = Greater Savings +140%

Findings from *Health in Housing: Exploring the Intersection Between Housing and Health Care*, February 2016

Enterprise® CORE | Center for Outcomes Research and Education

The Opportunity: Global to Local, Mercy Housing Northwest (MHNW) and Neighborcare have multicultural Community Health Worker (CHW) initiatives underway in 10 sites serving low-income residents, with high portion of immigrants, in Rainier Valley, High Point, SeaTac/Tukwila and Kent.

Through generous funding from PHPDA and other sources, these sponsors have developed CHW programs in Seattle and King County Housing authority sites, and other locations with a combination of: health education, wellness activities, screenings, and chronic disease management support targeted to Medicaid clients and other low-income residents. However, these programs lack metrics to demonstrate ROI. The CHW programs have some partnerships with FQHC's, but our hope is to achieve financially sustainable population health efforts similar to a Medicaid-funded CHW program in New Mexico where large savings from engaging high-need clients help support programming that serves a broader very low-income population. We envision closer clinical-community coordination to identify and refer residents with chronic health conditions, to track health costs and results and to mesh treatment plans with community-based supports.

The ACH could expand and improve the effectiveness and sustainability of these upstream efforts by adopting the Housing-Health Partnership as a Regional Health Improvement Project that would:

- Help set common service and interventions in these CHW projects aimed at health improvement and cost saving priorities in the Common Measure Set
- Support Public Health Seattle & King County in integrating Medicaid claims data and resident information to measure changes in health care costs for target sites and control group.
- Expand partnerships between Neighborcare, Health Point, other interested health centers and the CHW programs for HIPAA-compliant data sharing and treatment coordination. Incorporate a role for MCOs in program design and evaluation.
- Help assemble private/public funding for project coordinator and evaluation costs.
- Contribute members to advisory body to troubleshoot and glean lessons learned from the effort (can build on our existing Community Health Worker "smart colleagues" group)

Evolving the Community-Based Health Promotion Model: We would like help from ACH governance group to identify highest potential measures for ROI from the list below, and to help us set Regional Health Improvement Project (RHIP) goals that fit the scale of MHNW, Global to Local and Neighborcare Community Health Worker teams. Specific measures addressed and tracked could include: **1. Immunization: Influenza** – the project could facilitate influenza immunizations on-site at affordable and public housing communities and conduct outreach to encourage residents to get vaccinated; **10. Adult Access to Preventive / Ambulatory Health Services** – linkage to a medical home; **11. Adult BMI Assessment** – on-site BMI assessments for residents; activities and resources to assist residents in managing their weight, including physical activity and healthy cooking/nutrition education; **13. Colorectal Cancer Screening** – on-site colorectal cancer screenings; **14. Diabetes Care: Blood Pressure Control** – regular on-site blood pressure checks; reminders to clients via mobile phone; 15. Diabetes Care: Hemoglobin A1C – the project could provide mobile phone-based case management and support to clients to adhere to treatment plans and get regular A1C monitoring; **16. Hypertension: Blood Pressure Control** – the project could facilitate regular blood pressure checks as well as numerous healthy living activities designed to help residents control their blood pressure; **24. Screening: Cervical Cancer** - on-site cervical cancer screenings; **26. Screening: Breast Cancer** - on-site breast cancer screenings; **42. Potentially Avoidable ED Visits** – education on appropriate ED usage.

Project Strengths:
- CHW Collaboration. The Housing-Health Partnership has built collaborations with many relevant partners over the past 18 months. The underlying CHW costs are covered with existing grants. Global to Local is supported by Public Health, Swedish, Providence, and HealthPoint. They have invested in the CHW model and are potential partners for further interventions
- Data Integration. Public Health Seattle & King County, Seattle and King County Housing Authority have a Robert Wood Johnson Data Across Sectors for Health (DASH) grant; scope will include integration of Medicaid claims data with public housing and HUD data. Gates Foundation has funded MHNW to do initial scoping of affordable housing data integration. Global to Local has established protocols with HealthPoint for accessing and updating EMRs to reflect CHW activities and outcomes—an approach that could be replicated and scaled.
- Committed Resources. PHPDA, Communities of Opportunity, Bill & Melinda Gates Foundation, Enterprise have all committed significant resources.

Project Challenges:
- Resource Needs: To undertake this project as a RHIP will require, at minimum, multi-year funds for a project coordinator and for evaluation and data integration.
- Affordable Housing Shortage: This project will <u>not</u> produce housing, though the county is experiencing an unprecedented affordability and homeless crisis. The effort will improve the effectiveness of existing affordable housing to serve as a platform for improving health.
  - King County has 57,259 subsidized housing units with just over 10% (8,300) of these units designated for homeless. In 2016, at least 4,505 men, women, and children were without shelter in King County during the one night street count.
  - In Seattle alone, the gap between renter households and affordable and available rental housing units is greatest for lowest income households, where the gap is 67 units per 100 households—a shortage of 23,500 units. Unmet need (defined as very low-income household paying excessive amount for housing) is over 30,000 in Seattle and King County. New production of very affordable housing is about 800 units per year.

Additional Information:
- Public housing authorities (PHAs) provide three main types of housing assistance: Housing Choice Vouchers; Public Housing; and Project-based vouchers. Recent reports have explored the characteristics of public housing assistance recipients in Seattle, King County, and Washington State. See Characteristics of Public Housing Assistance Recipients in Washington State and Characteristics of Housing Assistance Recipients from Three Public Housing Authorities
- Seattle's Housing Affordability and Livability Agenda (HALA) is a multi-pronged strategy for addressing the housing affordability crisis in Seattle.
- The Washington State Community Health Worker (CHW) Task Force, was convened with the overarching purpose of developing policy and system change recommendations to align the Community Health Worker workforce with the work of the Healthier Washington initiative. See the Washington State Community Health Worker Task Force Final Report
- The Housing and Health Partnership, convened by Mercy Housing Northwest began with to provide guidance on developing a scalable, sustainable business model for housing-based health promotion efforts.

Housing-Health Partnership Participant List

Name	Organization
Kate Baber, Michele Thomas, Abi Velasco	Washington Low Income Housing Alliance
Adam Taylor	Global to Local
Alison Carl White	Better Health Together
Anne Farrell-Sheffer	YWCA Seattle King Snohomish
Anna Markee, Declan Wynne, Helen Howell	Building Changes
Betsy Lieberman, John Freeman	Betsy Lieberman Consulting
Bill Rumpf, Vy Lee, Katie Parker	Mercy Housing Northwest
Cheryl Markham	King County Community Services
Jeff Natter, Christina Bernard	PHPDA
Corina Grigoras, Tedd Kelleher, Nona White	Wa Dept of Commerce
David Wertheimer, Juan Sanchez	Bill & Melinda Gates Foundation
Erin Hafer, Kat Latet	Community Health Plan of Washington
	Boeing, Community Investor Health & Human
Gina Breukelman	Services
Giselle Zapata-Garcia, Jorge Rivera	Molina Health Care
Helen Howell	Building Changes
Jack Thompson, Tom Byers	Cedar River Group
Jennifer Ramirez Robinson, Elizabeth Westberg, Stephen Norman Sarah Oppenheimer	King County Housing Authority
Jim Mayfield	DSHS Research and Data Analysis,
Jon Brumbach	WA Health Care Authority
John Forsyth, Andrew Lofton	Seattle Housing Authority
Joy Lee	Public Health
June Robinson	State Representative
Kathy Burgoyne	Healthy Gen
Kelly Rider, Marty Kooistra	Housing Consortium
Kristen West, Jackie Adolphson	Empire Health Foundation
Lincoln Ferris	Seattle Central College
Lisa Yohalem	HealthPoint
M. A. Leonard, Amanda Saul	Enterprise Community Partners
Marguerite Ro, Amy Laurent	King County
Mia Navarro, Greg Claycamp, Michael Mirra	Tacoma Housing Authority
Nicole Olson, Hannah Cohen-Cline	Providence CORE
Pam Tietz	Spokane Housing Authority
Rebecca Burch	Washington State Health Care Authority
	Washington State Housing Finance
Rich Zwicker	Commission
Valerie Agostino	Mercy Housing national office
Zoe Reese, Katie Bell	Neighborcare

EXECUTIVE SUMMARY

This study, conducted by the Center for Outcomes Research & Education (CORE), directly explores the link between affordable housing and health care through the lens of several national health reform metrics: better connection to primary care, fewer emergency department (ED) visits, improved access to and quality of care, and lower costs.

This is one of the first studies to directly assess the impact on health care costs when low-income individuals move into affordable housing. Medicaid claims data were used to measure changes in health care costs and use, and survey data were used to examine health care access and quality. The study included 145 housing properties of three different types: family housing (FAM), permanent supportive housing (PSH), and housing for seniors and people with disabilities (SPD). The impact of integrated services within housing was also considered.

Four Key Findings

1 Costs to health care systems were lower after people moved into affordable housing.

- Total Medicaid expenditures declined by 12 percent.
- Declines in expenditures were seen for all housing types.
- IMPLICATION: *Access to affordable housing will likely drive down costs to the health care system.*

Overall	FAM	PSH	SPD
-12%	-8%	-14%	-16%

2 Primary care visits went up after move-in; emergency department visits went down.

- Outpatient primary care utilization increased 20 percent in the year after moving in, while ED use fell by 18 percent.
- Similar trends were observed for each housing type.
- IMPLICATION: *Affordable housing helps meet major health reform utilization metrics.*

Primary Care: **+20%**   ED Visits: **-18%**

3 Residents reported that access to care and quality of care improved after moving into housing.

- Many residents reported that health care access and quality were better after move-in than before; very few people reported it was worse.
- IMPLICATION: *Expenditure and utilization differences did not come at the expense of access or quality.*

ACCESS to health care after moving to affordable housing	Better	Worse	QUALITY of health care after moving to affordable housing	Better	Worse
	40%	4%		38%	7%

4 Integrated health services were a key driver of health care outcomes.

- The presence of health services was a driver of lower costs and ED use, despite low awareness among residents. (See Exhibits 1 to 21.)
- IMPLICATION: *Increasing use of these services may result in even greater cost differences.*
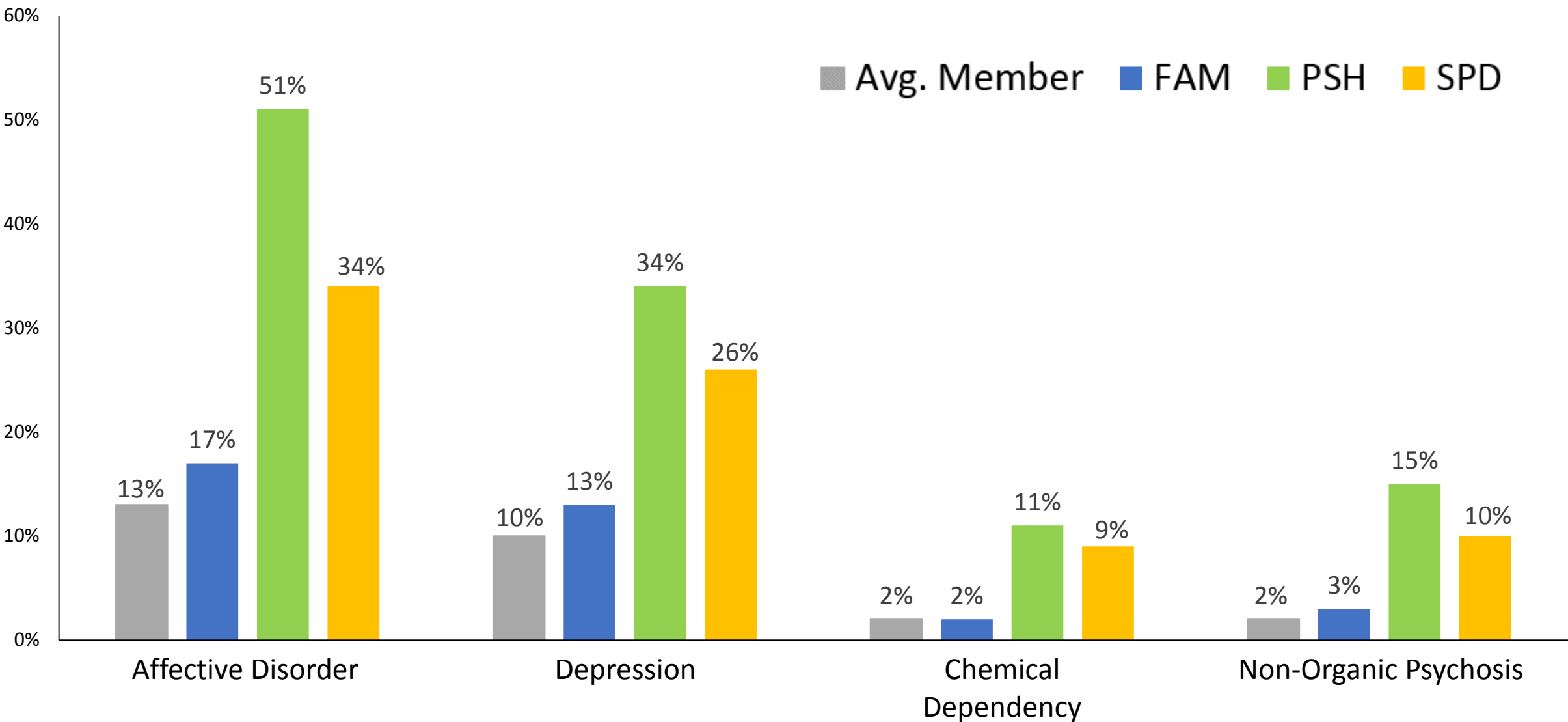
Adjusted impact of health services:

EXPENDITURES	-$115 member/month	ED VISITS	-0.43 visits/year

Prevalence of physical health diagnoses (claims data)
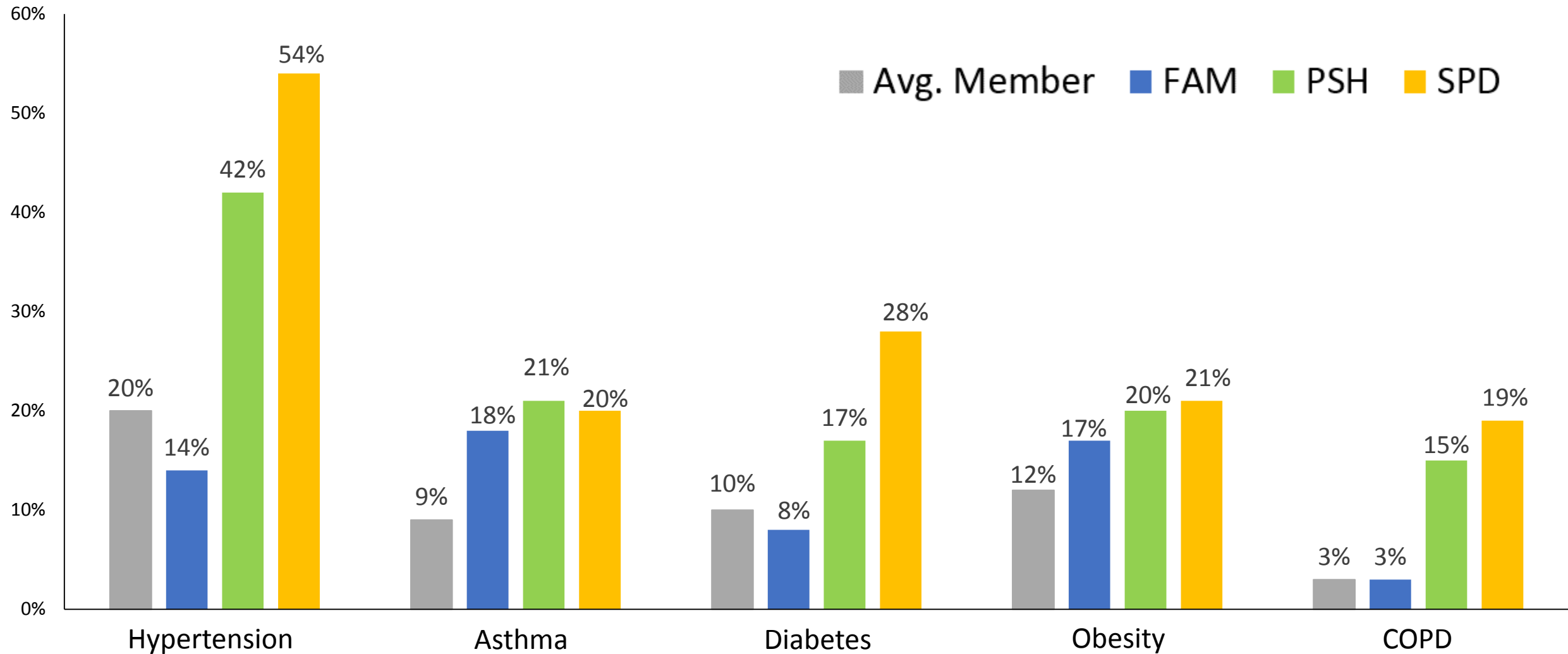
Prevalence of behavioral health diagnoses (claims data)

Accountable Communities of Health – Regional Health Improvement Project – Action Plan Template

PURPOSE:

This template is a tool for Accountable Communities of Health (ACHs) while selecting, planning, and implementing the regional health improvement project. Completing the template is required for the one project mandated under the SIM grant.

It is a working document that should be revised and updated as your project develops, so it can be used for communication within your ACH and with the Health Care Authority (HCA), Center for Community Health and Evaluation (CCHE), and technical assistance team (TA).

It is meant to facilitate project development and support alignment with state guidelines, but not undermine local project selection and implementation activities.

GUIDELINES:

The HCA has defined an ACH regional health improvement project as having:

- A set of coordinated, multi-sector activities
- A focus on one (or more) regional health priorities
- A design to produce measureable progress toward a health improvement goal

For additional HCA guidance, please see the ACH Health Improvement Project Requirements and Definitions document (see appendix).

SUBMISSION:

The HCA's deadline for ACH project submission is **no later than July 29, 2016, but** ACHs are expected to submit a **draft** version of the action plan template to HCA as soon as a project is identified before the July 29 deadline. This is because ACHs are encouraged to communicate early and often to help staff from HCA, CCHE, and TA provide feedback and resources in a timely manner to support project work.

Please complete the form below with as much information as you have available, while adhering to the instructions about content and length. Refer to the "ACH Action Plan example" document for additional information about how to fill out the form. Questions about completing and submitting the form below can be sent to the Community Empowerment & Accountability Team at HCA: CommunityTransformation@hca.wa.gov

BASIC INFORMATION

This section must be filled out and submitted to HCA before July 29, 2016 for project review and approval.

ACH:

Backbone staff contact (email, phone):

Key contact for project-related issues, if different than above (email, phone):

Date work plan was last updated:

1 – OVERVIEW

This section must be filled out and submitted to HCA before July 29, 2016 for project review and approval.

Project Title: Familiar Faces

County or Counties directly served by project: King

Brief description (*3-4 sentences*):

The Familiar Faces Initiative, a current initiative of focus for the King County region's Accountable Community of Health during its design year, is a broad-scale systems improvement effort focused on improving health and social outcomes for individuals booked into the King County Jail four or more times in a 12-month period who also have a mental health and/or substance use disorder- the Familiar Faces population. This Medicaid project would accelerate the refinement and testing of a core element of the Future State Vision: Community-Based Intensive Flexible Care Management Teams with connections to criminal justice system supports and the IT infrastructure and data necessary to support these teams.

Goal statement (*1-2 sentences*):

The goal of this project is to improve health and social outcomes for the Familiar Faces population by developing community-based flexible care teams that are able to serve the population wherever they are located and whenever clients are ready.

Project scope, please describe what part of your regional community the project will serve (e.g. three counties, patients enrolled with two health plans, four primary care clinics, approximate number of individuals served by a social service agency in one city) (*1-2 sentences*):

The project will serve individuals in the King County region who meet the criteria of being a "Familiar Face". Local data analysis of this population indicate that during calendar years 2013 and 2014, more than 1,273 and 1,252 individuals met this criteria. We anticipate the current population to be similar in size.

2 – STRATEGIC PLANNING & ALIGNMENT

This section must be filled out and submitted to HCA before July 29, 2016 for project review and approval.

This project is (*check one*): ☐ New   ☒ Enhancing an existing project or set of projects

The ACH's "value add" for this project (e.g., What difference does ACH involvement make to the project?) (*2-3 sentences*):

One of the biggest challenges has been gaining the "full picture" about the population including utilization patterns, costs and needs. This is because this population receives services across many different systems most of whom collect different data and do not share data with one another. To date, King County staff have spent a significant amount of time manually gathering, assembling and analyzing data from across many systems to be able to support the work. The added value of the ACH is that it would allocate greater focus and attention on developing a system that would allow data extraction and analysis across these multiple systems to better understand the needs of the population, in addition to developing the real-time capacity to better meet the needs of a complex and mobile population.

Rationale for this project (*up to half a page*), including:
- The regional health need or priority the project addresses, including how the need/priority was identified
- The significance for the region (i.e. how the project contributes to the community in a different way than other, existing programs or resources)
- Any evidence-based interventions, innovative practices, or models that informed the project idea

The Familiar Faces Initiative, a current initiative of focus for the King County region's Accountable Community of Health during its design year, was launched in 2015 as a "go first" strategy of the King County Health and Human Services Transformation Plan. To catalyze improvement in the system's performance for everyone, the plan called for an initial focus on areas where improved performance is most critical – for the individuals and communities experiencing the poorest outcomes. Following preliminary scoping conversations with several internal and community stakeholders during 2014, one of the initial populations of focus that emerged was individuals with a mental health and/or substance use disorder who are high utilizers of the local criminal justice system – specifically, the King County Jail- the so-called "Familiar Faces." Many of these individuals experience complex chronic health conditions including: histories of trauma, substance use disorders, mental health and chronic homelessness. These individuals experience instability in many aspects of their lives and are familiar to the various service and provider crisis systems. The Familiar Faces population was selected as an initial focus with the theory that if system improvements could be made that resulted in better health and social outcomes for these individuals, then the lessons learned would have much broader implications in how our region moves forward with the larger opportunities emerging as a result of the Affordable Care Act.

While innovative models of care management for the Medicaid population with complex needs continue to evolve, relatively few focus on individuals transitioning into and out of the criminal justice system, a group that includes many low-income adults with significant physical and behavioral health needs who face various economic, social, legal, and housing challenges. When the ACA expanded coverage, many previously uninsured adults with justice system involvement became eligible for Medicaid. Studies have found that justice system involvement has been associated with higher hospital and ED utilization, for example. Local data analysis of this population confirms the extent of complex health issues: a King County data analysis found that during calendar years 2013 and 2014, more than 1,273 and 1,252 individuals, respectively were booked into the King County Jail system four or

more times. Of these two cohorts; 94 percent had a behavioral health condition (including mental health and or substance use disorder), 93 percent had at least acute medical condition, 51 percent had at least one chronic medical condition, and more than 50 percent were homeless.

A recent report from the Center for Health Care Strategies, "Opportunities to Improve Models of Care for People with Complex Needs: Literature Review" [i] identifies a set of evidence-based strategies for improving outcomes and lowering costs for high-need, high-cost populations. The review cites care model aspects that have been associated with improved outcomes, such as the use of intensive, multi-disciplinary care teams, effective targeting, physical/BH integration, the incorporation of trauma-informed approaches, patient activation strategies, and addressing housing stability, among others. These key elements are found in the proposed project design for Familiar Faces. The CHCS literature review contains the key findings and outcomes (including cost reductions) for the most recent studies of care management models for high-risk, high cost populations. Examples include models such as Hennepin Health, whose preliminary results have shown a shift in care from ED and hospital to outpatient settings, and the percentage of patients receiving optimal diabetes, vascular, and asthma care has increased, as has patient satisfaction.

☐ Check box for TA help identifying resources to inform project strategy/design from the evidence-base/ pool of existing innovative practices.

Sectors and stakeholders engaged, please explain how your project meets the criteria of "a set of coordinated, multi-sector activities" (*2-4 sentences)*:

Organizations representing housing providers, substance use disorder providers, mental health providers, community health centers, Medicaid Managed Care Organizations, King County's Public Health department and Department of Community and Human Services, the City of Seattle, criminal justice organizations including courts, police, and the King County Department of Adult and Juvenile Detention have been engaged in the initiative and are represented on the Familiar Faces Steering Committee, which is responsible for overseeing the development, launch and refinement of strategies to improve outcomes for the population. These organizations were involved in the development of the Familiar Faces Future Vision- a map that outlines the system of care that is driving these strategies, including the community-based flexible care teams.

3 – KEY ACTIVITIES & TIMELINE
Please describe the various ACH project activities that demonstrate incremental progress towards the overall project goal. Add additional rows for project activities as needed. Indicate the activities where the ACH could benefit from TA support to operationalize the plan.

ACHs may proceed with project activities faster than outlined below, but will be expected to make progress according to the following deadlines:

- *Activity descriptions for the August 2016 – January 2017 period should include concrete action planning steps, such as: working collaboratively to finalize project details, confirming key stakeholder commitment to the project, developing tools or materials necessary for implementation, confirming specific implementation sites (if appropriate), etc.*
- *Activity descriptions for February 2017 and beyond can be less detailed, but should provide a high-level picture of the next key steps in project implementation. (Additional concrete project implementation steps will be due by January 31, 2017).*

Activity	Contributing stakeholders, their roles & responsibilities	Timeline	Need TA help?
Finalize Contacts with Providers for Intensive Flexible Care Team Pilot	King County Department of Community and Human Services- work with the providers to finalize contracts	May – June 2016	
Launch Intensive Flexible Care Team Pilot	King County Department of Community and Human Services Harborview Medical Center Evergreen/Reach Law Enforcement Assisted Diversion Plymouth Housing	July, 2016	☐
Collect Data	King County Department of Community and Human Services Harborview Medical Center Evergreen/Reach King County Law Enforcement Assisted Diversion Plymouth Housing	Ongoing beginning in July, 2016	☐
Analyze Data	Familiar Faces Steering Committee Providers involved in pilot strategies	Monthly beginning in October, 2016	☐

4 – MEASURING SUCCESS: PROJECT OUTCOMES & DATA

This section must include initial ideas and plans to submit to HCA before July 29, 2016, but does not need to be filled out completely.

More details in this section will be required by HCA before October 31, 2016.

Please describe how you plan to measure progress towards your ACH project goal. Add additional rows if needed. Indicate where the ACH could benefit from CCHE coaching to identify feasible outcome measures, data sources, and analysis plans for the ACH's official SIM project.

Outcome (Desired result)	Outcome indicator (How success is measured)	Data source	Stakeholder(s) helping w/ data collection or analysis	Timeline	Need CCHE help?
Improved health status	Use of Preventive/Ambulatory care Reduced substance use	Provider1 claims data TBD	Familiar Faces steering committee	Baseline and 1-yr follow up for people touched by care teams	☐
Improved housing stability	Attainment of housing/reduced homelessness	HMIS	Familiar Faces steering committee	Baseline and 1-yr follow up for people touched	☐

	Retention in housing for 12+ months (HUD)	TBD		by care teams	
Reduced criminal justice involvement	Reduced jail admissions and days	DAJD data	Familiar Faces steering committee	Baseline and 1-yr follow up for people touched by care teams	☐
Reduced avoidable ED visits	Reduced avoidable ED visits	Provider1 claims data and/or PreManage	Familiar Faces steering committee	Baseline and 1-yr follow up for people touched by care teams	☐
Improved client satisfaction with quality of life (QOL)	Improved WHOQOL physical, emotional, social QOL	TBD	Familiar Faces steering committee	Baseline and 1-yr follow up for people touched by care teams	☐

Connection to the statewide Common Measure Set, please explain how the project measures and overall goal will help improve one or more of the metrics from the Common Measure Set (*up to 3 sentences*): The Familiar Faces population engages in services across a number of different silos, funded by different sources, consisting of different programs. A key aspect of the initiative is to test whether lasting improvements can be achieved by bringing different sectors together to focus on a set of shared outcomes. To minimize additional data collection for those sectors involved in the Initiative, the outcome indicators that have been selected are directly derived from the Common Measure Set.

☐ Check box for additional help from CCHE on connecting the project to the Common Measure Set.

Advancing the Triple Aim, please describe how successful implementation of the project would contribute to one or more component of the Triple Aim in your community – i.e. (1) improving services (quality of care, patient experience); (2) reducing health-related costs, and (3) improving health and wellbeing in your region (*up to 4 sentences*):

While there is no shortage of programs in the region that are designed to address the needs of the Familiar Faces – many of which produce excellent results as stand-alone programs – overall fragmentation, uncoordinated care, poor outcomes and growing costs persist for the health, social services, and criminal justice systems, and for our community overall. By re-making the system into one that is client-centric rather than program-centric, is flexible, able to meet the needs of clients whenever they are ready and wherever they are, we anticipate that we will be able to make progress towards all three components of the Triple Aim.

5- WRAP-UP QUESTIONS

This section must be filled out and submitted to HCA before July 29, 2016 for project review and approval.

What top two challenges are you currently concerned about the project? (*2-3 sentences*):

The top challenges currently impacting the Familiar faces initiative are related to data and policy/system barriers to care coordination. As mentioned previously, one of the biggest challenges has been gaining the "full picture" about the population including utilization patterns, costs and needs. This is because this population receives services across many different systems most of whom collect different data and do not share data with one another. Additionally, there are policy and system barriers to properly coordinating care for this unique population that need to be addressed in order to achieve optimal outcomes. These barriers are both Federal and State-based in origin, such as those related to 42 CFR and the ability to share certain behavioral health information with other providers and community-based organizations.

What top two strengths in your region make you feel confident about making progress? (*2- 3 sentences*):

The top strengths that will allow the Familiar Faces initiative to continue to make progress are the collective involvement and support from our community partners and the ongoing support from King County leadership behind this effort. Steering Committee representatives understand that achievement of the Familiar Faces future-state vision is a multi-year effort and will require ongoing support and guidance to achieve, and are committed to this accordingly. In collaboration with this, King County Government has dedicated significant investments to the Familiar Faces initiative and will continue to support the work and efforts towards the desired outcomes and connection to the King County Transformation Plan.

Do you have any questions or need clarification from HCA? (*2-3 sentences*):

If chosen, how does being selected as the RHIP under the SIM grant affect or inhibit the Familiar Faces initiative from being considered as a formal project inside of the 1115 Medicaid Waiver 'Project Toolkit'?

APPENDIX – Health Care Authority guidance on selection and requirements for official SIM project:

Copy guidance language here when ready.

i http://www.chcs.org/media/HNHC_CHCS_LitReview_Final.pdf

Familiar Faces Future State Vision v.1.6 DRAFT

Transportation

Physical and Behavioral Health Care **FF**

FF Database

Basic Needs

Mobile Care Response **FF**

Mobile Client Outreach **FF**

Drop In Campus **FF**

Employment

Single Care Plan

Preventive and Pre-Crisis

Crisis Diversion Options

Spirituality

Housing **FF**

Familiar Face

Golden Thread

Crisis (Rare)

Hospital **FF**

Benefits

EMS **FF**

Fire **FF**

Care Management Team **FF**
Meets FF wherever they are

Jail **FF**

Community

Police **FF**

Family

Education

Legal

Courts

— Person Centered — Motivational Interviewing Methods — Trauma Informed — Harm Reduction — Evidence Based — Irrelevant of Payor —

Revised 9/7/2015
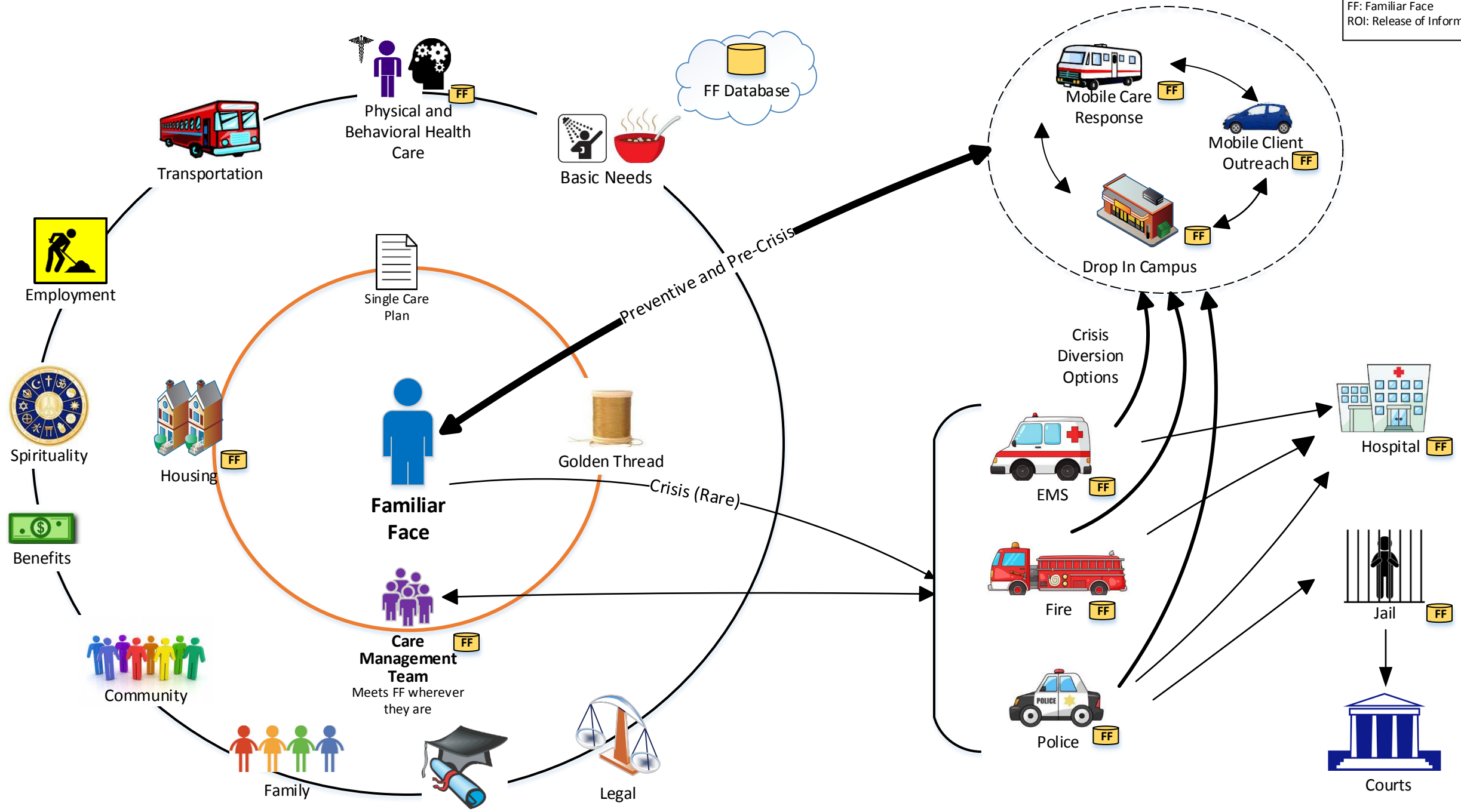
KING COUNTY PATHWAY TO FULL INTEGRATION

King County Accountable Community of Health

June 6, 2016

Susan McLaughlin, Ph.D.

Department of Community and Human Services

What the 6312 Legislation Says

- Calls for the integrated purchasing of mental health and substance abuse treatment (collectively, behavioral health) services through a single managed care contract by April 1, 2016
  - **DONE!** King County BHRD became the regional Behavioral Health Organization
  - Integrated mental health and substance use treatment
  - Moved SUD system to managed care

- Calls for *full integration* of mental health, substance abuse and physical health care by January 1, 2020
  - Both clinical and financial aspects

Key Decisions to be made

- What will the financial infrastructure for Fully Integrated Managed Care (FIMC) be and what is the optimal role of the County

- What clinical model(s) of care do we want to see in our region
  - Different models have varying impact on the adequacy of care

- What is our timeline for implementation of full integration

- What will the payment structure look like (for providers)
  - How do we get to value based payments

Landscape of Full Integration Work in King County

King County Accountable Community of Health

King County/WA State Leadership Table

King County Integration Design Committee (IDC)

King County Internal Workgroup
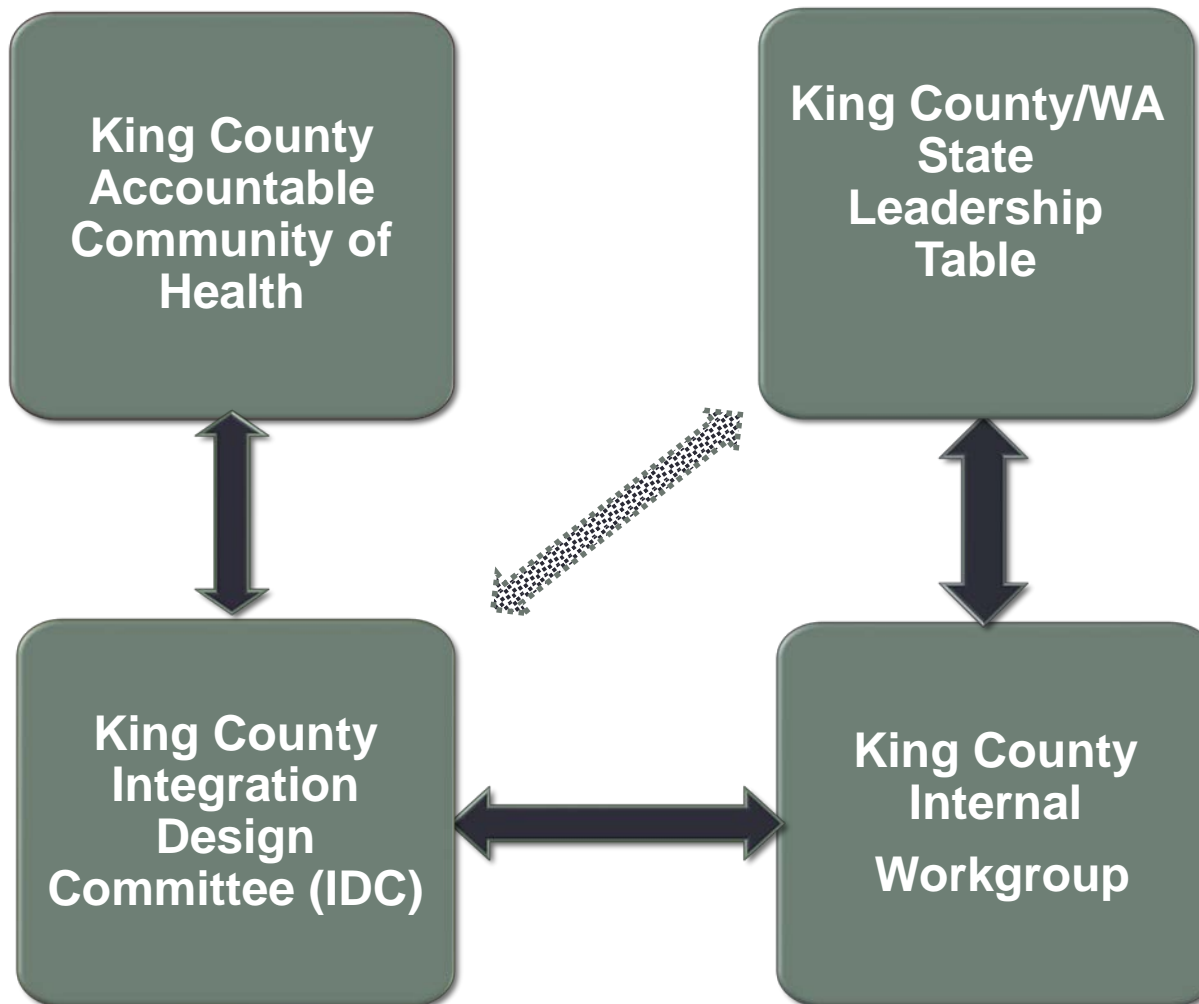
King County Accountable Community of Health (ACH)

- **Who is participating?**
  - Regional cross-sector partners: hospital systems, social service providers, health and behavioral health providers, housing providers, Medicaid Managed Care, local government (including King County).

- **What is the purpose?**
  - Identify regional health priorities
  - Support and further efforts to improve health care, lower costs and improve outcomes in the region.
  - Build on 4 priority areas where work is already happening, including physical and behavioral health integration.
  - Serve as a regional voice to the state about regional health priorities and how to further the work to achieve the triple aim.
  - Work across siloes to address the many factors that influence health (social determinants), not just access to health care.

King County/Washington State Leaders

- **Who is participating?**
  - Department of Community and Human Services, Behavioral Health and Recovery Division, Executive's Office, Public Health- Seattle & King County, Governor's Office, Health Care Authority, Department of Social and Health Services

- **What is the purpose?**
  - Negotiate critical aspects of a Fully Integrated Managed Care model (for Medicaid population) for King County;
  - Maintain alignment between state goals and County goals
  - Establish a timeline and work plan for implementation on the decided regional timeline

King County Full Integration Workgroup

- **Who is participating?**
  - Internal King County Staff: Public Health, Behavioral Health and Recovery Division, Executive's Office, Office of Performance Strategy and Budget; Department of Community and Human Services

- **What is the purpose?**
  - Explore potential roles for King County in providing Fully Integrated Managed Care (FIMC)
  - Study and bring to the work aspects of other national integration efforts
  - Examine risks and benefits of various FIMC models
  - Synthesize and summarize activities of internal work, IDC, and state negotiations to develop a recommendation for a path forward

Physical and Behavioral Health Integration Design Committee (IDC)

- **Who is participating?**
  - Representatives from key sectors in the King County Region including MCOs, behavioral health, physical health, housing providers

- **What is the purpose?**
  - Recommend a model(s) of fully integrated care to serve **Medicaid clients and other vulnerable populations for the King County region**;
  - Advise King County on a path forward for Fully Integrated Managed Care, including a timeline that reflects the readiness of our community
  - Deliver recommendations to the King County Accountable Community of Health for their endorsement as a regional body
  - Deliver recommendations to the King County Executive and Council to inform decision making regarding FIMC

Key considerations for IDC

- Care delivery models:
  - Children/youth, adults, older adults, non-traditional/hard to serve
  - What does a full continuum look like – where are the gaps
  - How and who should manage crisis services: one system versus multiple
  - Core components that need to be standard, community based and/or payer blind
- How best to maintain current infrastructure and investments if responsibility is transferred
- How best to manage risk across key players
- How to capture and share savings for reinvestment in community
- How to move the system to value based purchasing

IDC Process

- Four workgroups established

  - Children/youth (Clinical)
  - Adults/older adults (Clinical)
  - Non-traditional/hard to serve (Clinical)

  Develop a clinical model(s) across the life span

  - Infrastructure/Financing

  Evaluate infrastructure options to best support clinical model(s)

- Initial recommendations by September
- Final recommendations by October

HCA Full Integration Timelines*

Activity	2017 Adoption	2018 Adoption	2020 Adoption
HCA/Regional Engagement Begins	Now		
Non-Binding Letter of Intent	5/1/2016	5/1/2017	11/1/2018
County Engagement/Model Discussion/Finalize Model	7/1/2016	7/1/2017	1/1/2019
Binding Letter of Intent	8/1/2016	8/1/2017	2/1/2019
Release RFP	9/1/2016	9/1/2017	3/1/2019
RFP Response Due	11/1/2016	11/1/2017	5/1/2019
Announce Successful Bidders	1/1/2017	1/1/2018	7/1/2019
Sign Contracts	2/1/2017	2/1/2018	8/1/2019
Readiness Review	2 - 7/2017	2-7/2017	8/1/2019-1/1/2020
Contract Start	7/1/2017	7/1/2018	1/1/2020

*Subject to modification as needed

King County Decision Making Timeline

Decision	Dates
What will the financial infrastructure for FIMC look like? - What is the optimal role of the County	Fall 2016
What is the desired clinical model(s) including crisis system	Fall 2016
Timeline for implementation of full integration (will we be a mid-adopter?)	By the end of the year (2016)
What will the payment structure look like - Value based payment models, etc.	Dependent on implementation timeline

Decision Making Structure

Work Happens Here

Decisions Happen Here

King County Accountable Community of Health

King County/WA State Leadership Table

King County Integration Design Committee (IDC)

King County Internal Workgroup

King County Executive and King County Council
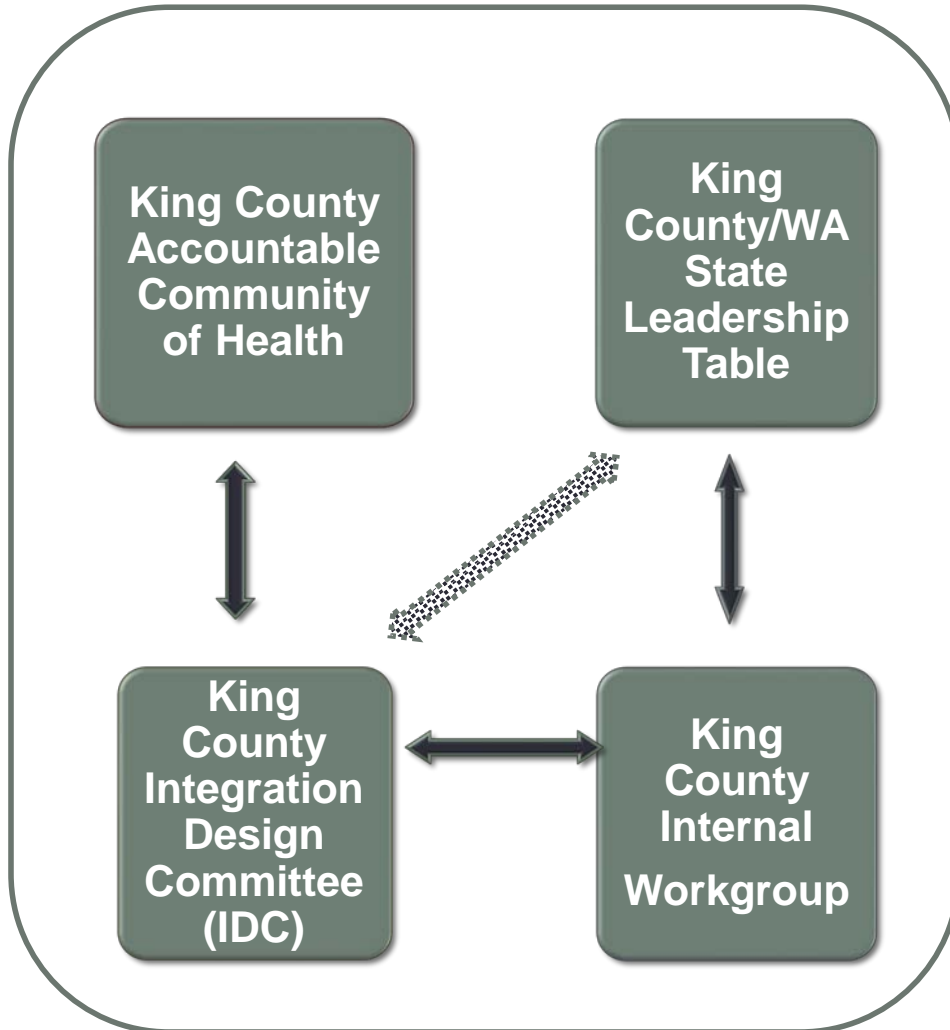
Informs/influences

Washington State Leaders
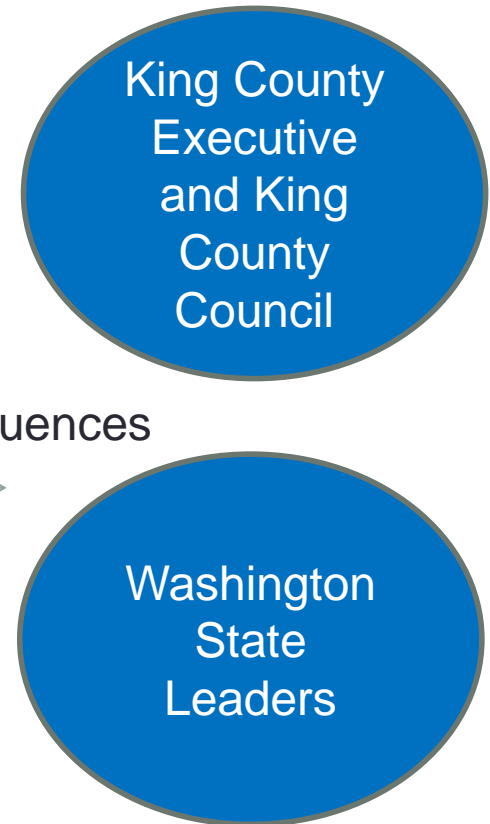
ACH - HEALTHIER WASHINGTON DASHBOARDS

INITIAL DATA AND MEASURES FOR DASHBOARDS

DATA SOURCES	MEASURES	DIMENSIONS
Data sources are provided by HCA and DOH and dictate the possible measures and dimensions (filters and views of those measures) included in the dashboards.	Dashboard will include a subset of measures from the Common Measure Set. More measures will be included over time with each release as ACH focus areas arise.	We will develop multi-dimensional views of the measures that can be explored through filters and visualizations. Claims-based measures will be available with the following filters and views:

FIRST RELEASE

DATA SOURCES
HCA Medicaid Claims
HCA Medicaid Enrollment
DOH Immunization

MEASURES
HCA Medicaid Data, Claims-Based (2015)
1. Child and Adolescent Access to PCP
2. Adult Access to Preventive/Amb. Care
3. Diabetes – Eye Exam
4. Diabetes – Blood Sugar (HCA1c) Test
5. Diabetes – Kidney Disease Screening

DOH Immunization (2015)
1. Childhood immunization status
2. Immunizations for adolescents
3. HPV vaccine for adolescents (by sex:M/F)
4. Influenza immunization

DIMENSIONS FIRST RELEASE (Medicaid Data Filtering Only)
-Geographic Region: State, ACH, County, Zip Code, School Distract, Legislative District
-Race/Ethnicity
-Age: Adult/Child
-Gender
-Language: Top 10 languages

FUTURE RELEASE

DATA SOURCES
HCA PEB Claims
DOH BRFSS (Agg)
DOH PRAMS (Agg)
OTHER - TBD

MEASURES
Potentially Avoidable ED Visits
ACH Preference - TBD

DIMENSIONS
Diagnoses
Measures of Risk/Complexity
Other - TBD

FINAL PRODUCT: INTERACTIVE DASHBOARDS THAT ARE REFRESHED THROUGHOUT THE YEAR

Data Resources for Accountable Community of Health (ACH) Regions
April 6. 2016

The following is a draft matrix of data resources offering menu driven analysis or summary statistics which can be used for needs assessment, project prioritization and program planning. Most of the identified resources allow analysis by Accountable Community of Health (ACH) regions. Those resources not yet available by ACH regions can be analyzed by county or other sub-state geography. Many of these resources are available   publicly, and when not public, are available to local health jurisdiction assessment coordinators. Many local health jurisdictions already have community health assessments or have worked with hospital   partners on community health needs assessments. They are a great resource to contact when working on regional needs assessments, prioritizations and planning. A list of local health assessment coordinators   is available here.

Category	Data Source	Description	Tutorial	Link
Washington Tracking Network	Variety	Environmental, health and social determinant information are available by location across Washington. Environmental health hazard data include air quality, drinking water, radon, lead, and biomonitoring. Health outcome data include asthma, low birth weight, fertility, prematurity, cancer, heart attack, heat stress and injury. Social determinant data include: education, poverty, single parent household, unemployment, unaffordable housing, unaffordable transportation, and limited English speaking. Data are available by census tract. Data are constantly being added and updated. In the future, an ACH boundary map will be added.	N/A	http://www.doh.wa.gov/DataandStatisticalReports/EnvironmentalHealth/WashingtonTrackingNetworkWTN
Community Commons	Variety	Demographic, social and economic, physical environment, clinical care, health behaviors and health outcome data available from a wide variety of data sources. Can create report area equivalent to ACH regions. Reports are customizable and include mapping capability and ability to	http://www.communitycommons.org/cchelp/cc_help_topics/reports/	http://www.communitycommons.org/
Community Checkup	Claims data from commercial and Medicaid plans	An annual report and website produced by the Washington Health Alliance that provides claims-based summary data on the quality of primary care, treatment of chronic conditions, and patient satisfaction with care. Data available on the hospital, medical group, clinic and county level.	N/A	http://www.wacommunitycheckup.org/resources/alliance-reports
Population	CHAT[1]	Population by age, race/ethnicity and geography based on Office of Financial Management	Upon Request	See CHAT note below
Population estimates	Population estimates	Intercensal estimates available in excel tables on a routine basis, and updated yearly by the Office of Financial Management. Race/ethnicity, age, gender, by city, county, and census areas	N/A	http://www.ofm.wa.gov/pop/april1/default.asp

Social Determinants	Census/ American Community Survey	Housing, income, language spoken, household makeup, race/ethnicity and other demographics	http://factfinder.census.gov/legacy/quickstart.html	http://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml
Maternal and Child Health	CHAT[1]	Fertility, pregnancy rates, low birth weight, preterm delivery, infant mortality, prenatal care, pre-pregnancy weight, smoking, weight gain, parity, pregnancy morbidity, delivery method,	Upon Request	See CHAT note below
Behavioral Health	SCOPE	The Washington State Division of Behavioral Health & Recovery SCOPE-WA is a web-based query and reporting service for substance and mental health professionals across Washington State.	Upon Request	http://www.scopewa.net/Account/LogOn?ReturnUrl=%2f
Chronic Disease	CHAT[1]	Hospitalization and mortality data, including alcohol-related and drug-related. Need to identify ICD-9-CM and ICD-10-CM relevant codes.	Upon Request	See CHAT note below
Injury	CHAT[1]	Hospitalization and mortality data, including alcohol-related and drug-related. Need to identify ICD-9-CM and ICD-10-CM relevant codes.	Upon Request	See CHAT note below
Communicable Diseases	CHAT[1]	Notifiable conditions, Tuberculosis, Sexually Transmitted Diseases	Upon Request	See CHAT note below
Risk and Protective Factors	Healthy Youth Survey	School-based survey of students in grades 6, 8, 10 and 12. Frequency reports are available by Regional Service Areas which largely map to ACHs. Topics include smoking, substance use, nutrition, physical activity, screen time, mental health and suicide, bullying and school climate, sexual behavior, weapon carrying, and more.	Webinar presentations available at: http://www.askhys.net/Training Links to brief training videos at bottom of survey results pages. www.askhys.net	www.ASKHYS.net
Chronic Disease Profiles	American Community Survey, Healthy Youth Survey, Behavioral Risk Factor Surveillance	8-page data report including demographics, food insecurity, physical activity, cigarette smoking, alcohol use, obesity, asthma, diabetes, heart disease, preventative care, Reports currently available by county.	N/A	http://www.doh.wa.gov/DataandStatisticalReports/DiseasesandChronicConditions/ChronicDiseaseProfiles
Immunizations	Washington Immunization Information System	Kindergarten, 6th grade and K-12 (All Grades) school immunization coverage. Reports currently available by county and educational service district.	N/A	http://www.doh.wa.gov/DataandStatisticalReports/HealthBehaviors/Immunization/SchoolReports
Washington State Data Portal	Variety	Wide variety of data reports available organized by agriculture, demographics, economics, education and health. Some data are available by county.	N/A	https://data.wa.gov/

Category	Data Source	Description	Tutorial	Link
Health Professional Shortage Areas	Health Professional Shortage Areas	Geographic areas and populations within Washington designated by the Health Resources and Services Administration to have shortages of primary medical care, dental or mental health providers.	N/A	http://hpsafind.hrsa.gov/HPSASearch.aspx Additional information on HPSAs: http://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/RuralHealth/DataandOtherResources/HealthProfessionalShortageAreas
Food Stamps	USDA Food Stamps	Supplemental Nutrition Assistance Program data by Congressional District.	N/A	http://www.fns.usda.gov/ops/snap-community-characteristics-washington
Supplemental Nutrition Program for Women Infants and Children (WIC)	WIC	Annual summary data of women, infants and children served by county.	N/A	http://www.doh.wa.gov/portals/1/Documents/Pubs/960-221-2013WICDataByCounty.pdf
Office of the Superintendent of Public Instruction Data	OSPI	Summary reports including demographics, graduation rates, absences, WaKIDS scores, testing results, teacher information, and other school measures. Available by educational service district.	N/A	http://reportcard.ospi.k12.wa.us/Summary.aspx?domain=MSPHSPE&year=2013-14&groupLevel=ESD&schoolId=1&reportLevel=State&gradeLevelId=3&waslCategory=1&yrs=2013-14
Homeless Count	Point in Time Count	Count of sheltered and unsheltered homeless persons in Washington State by county.	N/A	http://www.commerce.wa.gov/Programs/housing/Homeless/Pages/ContinuumofCareHomelessAssistanceProgram.aspx (information) http://www.commerce.wa.gov/Programs/housing/Homeless/Pages/Annual-Point-In-Time-Count.aspx (Point in time count)
Workfirst Local Planning Area Performance	Workforce	Performance data available by local planning area.	N/A	http://www.workfirst.wa.gov/performance/measures.asp
Local Public Health Indicators	Variety	Access to care, communicable disease, environmental health, maternal and child health, prevention and health promotion indicators available at the county level and developed to inform state and local public health programs and policies.	N/A	http://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/PublicHealthSystemResourcesandServices/PublicHealthImprovementPartnership/LocalPublicHealthIndicators
EWU Community Indicators Projects	Variety	Links to community indicators projects for selected counties in Washington/Idaho/California managed by Eastern Washington University and its partners. Data include demographics, culture, economic vitality, education, environment, health, housing, public safety and transportation.	N/A	http://www.ewu.edu/cbpa/centers-and-institutes/ippea

Category	Data Source	Description	Tutorial	Link
Community Health Status Indicators	Variety	County health profiles including health outcomes, behaviors, health care access, social determinants and physical environment. Counties are compared to peer counties across the US. Developed by Centers for Disease Control.	http://wwwn.cdc.gov/CommunityHealth/info/HowtoUseReport	http://www.cdc.gov/communityhealth
Washington County Profiles		Links to county budget and county comprehensive plans are generally available from this site, although some links are broken.	N/A	http://mrsc.org/Home/Research-Tools/Washington-County-Profiles.aspx
County Health Rankings	Variety	Rankings of counties within Washington on a variety of factors including premature death, quality of life, health behaviors, availability of providers, clinical practices, physical environment and social determinants of health.	Tutorial on taking action to improve community health: http://www.countyhealthrankings.org/roadmaps/action-center	http://www.countyhealthrankings.org/app/washington/2015/overview
WaMONAHRQ	Comprehensive Hospital Abstract Reporting System	Washington State MONAHRQ (WaMONAHRQ) is an information system of hospital inpatient care utilization, quality, and potentially avoidable stays in Washington State's community hospitals and by Washington's residents. Data available by county and potentially other custom ZIP-code based areas.	N/A	http://www.wamonahrq.net/
DSHS Research and Data Analysis Division Client Counts and Service Costs	DSHS administrative data for publically funded health and human services	Aggregate, anonymous statistics about DSHS clients including the unduplicated number of clients served, use rates (percent of population receiving services), and direct service expenditures for all DSHS programs. Data are added to the reports as they become available. Data available by county, legislative district, city, and school district.	N/A	https://www.dshs.wa.gov/sesa/research-and-data-analysis/client-data
UDS Mapper	Uniform Data System	An interactive Zip Code Tabulation Area (ZCTA)-level mapping website. The information available in the UDS Mapper includes estimates of the collective service area of federally qualified health centers (FQHCs) and FQHC-look alike health centers by ZCTA, including the ratio of Health Center Program grantee and look-alike patients reported in the Uniform Data System (UDS) to the target population, the change in the number of those reported patients over time, and an estimate of those in the target population that remain unserved by HCP grantees and look-alikes reporting data to the UDS (but may be served by other providers).	http://www.udsmapper.org/tutorials-and-resources.cfm	http://www.udsmapper.org/
Healthy People 2020	Variety	A snapshot of national data and goal for 2020. Provides definitions and data sources for over 1,200 indicators (by city, county, and census areas), with some rationale about why it is important.	https://www.healthypeople.gov/2020/How-to-Use-DATA2020	https://www.healthypeople.gov/2020/data-search/Search-the-Data

Category	Data Source	Description	Tutorial	Link
Qualis' Community Performance Reports	Claims data from Medicare	Care transitions data for Medicare clients	N/A	http://medicare.qualishealth.org/projects/care-transitions/news-and-progress/specific-communities/performance-reports

Other Resources

Community Health Assessment and Improvement		This site provides a basic overview of what a community health assessment is, links to additional resources, tools, and examples, and includes a table that displays links to recent Community Health Assessments (CHA) and Community Health Improvement Plans (CHIP) completed by Local Health Jurisdictions (LHJ) and Community Health Needs Assessments (CHNA) completed by hospitals		http://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/PublicHealthSystemResourcesandServices/CommunityHealthAssessmentandImprovement
Community Health Assessments & Community Health Needs Assessments		Links to recent Community Health Assessments (CHA) and Community Health Improvement Plans (CHIP) completed by Local Health Jurisdictions (LHJ) and Community Health Needs Assessments (CHNA) completed by hospitals		http://www.doh.wa.gov/Portals/1/Documents/1200/assess.pdf
Public Health Centers of Excellence		This is a partnership between Spokane Regional Health District and the Tacoma-Pierce County Health Department to provide consulting services to public and tribal health agencies working on quality improvement and accreditation. They offer a number of services including community assessment, planning and program evaluation.		http://www.phcentersforexcellence.org
The Consolidated Housing and Community Development plans		Key source of data about housing, homeless, and general community development needs/conditions in given areas. Produced every 3-5 years. Cities, consortia, and states are all entities that may produce the Consolidated Plan.		A Links to all plans developed in Washington state is found here: https://www.hudexchange.info/consolidated-plan/con-plans-aaps-capers
Area Agency on Aging plans		The plans include a data profile/trends/need information.		A link to the local Area Agency on Aging plans that cover Washington state: http://www.agingwashington.org/area-agencies-on-aging
Federal Community Services Block Grant (CSBG)		Provides funding to help alleviate poverty and revitalize communities (requires that specific community action agencies complete a community needs assessment and associated action plan.		This is the link to the state site and statewide plan, which includes a listing of the Community action agencies across the state: http://www.commerce.wa.gov/Documents/CSBG%202015-2016%20DRAFT%20State%20Plan.pdf

[1]CHAT, Community Health Assessment Tool, provides secure web-based access to a repository containing data collections gathered and maintained by the Washington State Department of Health (DOH). The CHAT tool can assist Local Health Jurisdictions and other public health professionals at DOH in the development of public health assessment reports. At the heart of CHAT is a repository built from the annual release of detailed information on birth outcomes, causes of death, injuries, communicable diseases, hospitalizations, cancer incidence and population demographics. For data on these topics, please contact your local health assessment coordinator.